United Nations A/HRC/34/32

General Assembly

Distr.: General
31 January 2017

Original: English

Human Rights Council
Thirty-fourth session
27 February-24 March 2017
Agenda items 2 and 3
Annual report of the United Nations High Commissioner for Human Rights and reports of the Office of the High Commissioner and the Secretary-General

Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Mental health and human rights

Report of the United Nations High Commissioner for Human Rights

Summary

The present report, mandated by the Human Rights Council in resolution 32/18, identifies some of the major challenges faced by users of mental health services, persons with mental health conditions and persons with psychosocial disabilities. These include stigma and discrimination, violations of economic, social and other rights and the denial of autonomy and legal capacity.

In the report, the High Commissioner recommends a number of policy shifts, which would support the full realization of the human rights of those populations, such as the systematic inclusion of human rights in policy and the recognition of the individual's autonomy, agency and dignity. Such changes cover measures to improve the quality of mental health service delivery, to put an end to involuntary treatment and institutionalization and to create a legal and policy environment that is conducive to the realization of the human rights of persons with mental health conditions and psychosocial disabilities.

GE.17-01400(E)
1701400

Please recycle

Contents

I. Introduction
II. Terminology and background
III. The right to health framework
IV. Challenges with implications for human rights in mental health
A. The experience of living with mental health conditions
B. Systemic challenges applicable to mental health
V. The human rights-based approach to disability in the context of mental health
A. Equal recognition before the law
B. The absolute ban on deprivation of liberty on the basis of impairments
C. Forced treatment: forced medication, overmedication and harmful practices during deprivation of liberty
VI. Charting the way forward
A. Human rights-based approach
B. Good practices
C. Technical support and capacity-building
VII. Conclusions

Page

3
3
4
5
6
7
9
9
10
11
11
12
15
17
18

I. Introduction

1. On 1 July 2016, the Human Rights Council adopted resolution 32/18 on mental health and human rights. In the resolution, the Council requested the High Commissioner to prepare a report on the integration of a human rights perspective in mental health and the realization of the human rights and fundamental freedoms of persons with mental health conditions or psychosocial disabilities, including persons using mental health and community services, and to submit the report to the Human Rights Council at its thirty-fourth session. The Council specified that the report should identify existing challenges and emerging good practices, make recommendations in that regard and identify means of strengthening technical assistance and capacity-building, taking into account existing activities and experiences in this area.

2. The Office of the United Nations High Commissioner for Human Rights (OHCHR) invited submissions from a range of stakeholders, including Member States, special procedure mandate holders, United Nations human rights treaty bodies, the World Health Organization and civil society organizations. OHCHR received a total of 40 submissions, of which 18 were contributed by Member States.[1] Although the High Commissioner does not reference individual submissions, they were an important source of the research on which the report draws, particularly in relation to challenges and recommendations.

3. Given the extensive scope of the resolution, and the fundamentally broad nature of the human rights, mental health and disability agendas, the report is focused on providing an overview of some of the most significant challenges faced by the groups identified in the resolution, the normative framework applicable to their human rights and policies and practices, which would support their full realization. The report also makes recommendations in these areas, as well as in relation to capacity-building and technical support.

II. Terminology and background

4. The right to the highest attainable standard of physical and mental health is a fundamental human right indispensable for the exercise of other human rights.[2] Health describes a state of "complete physical, mental and social well-being and not merely the absence of disease or infirmity".[3] Mental health may, in its turn, be defined as "a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community".[4] In the case of children and adolescents, mental health refers to "the capacity to achieve and maintain optimal psychological functioning and well-being".[5]

5. Three different categories should be clearly distinguished among those referred to in resolution 32/18: persons using mental health services (who are current or potential users of

[1] Submissions were received from the following Member States: Australia, Bolivia (Plurinational State of), Brazil, Colombia, Egypt, Germany, Guatemala, Hungary, Ireland, Jamaica, Monaco, Netherlands, Oman, Portugal, Qatar, Republic of Moldova, Saudi Arabia and Serbia.

[2] See Committee on Economic Social and Cultural Rights, general comment No. 14 (2000) on the right to the highest attainable standard of health, para. 1.

[3] Constitution of the World Health Organization (WHO), preamble.

[4] See www.who.int/mediacentre/factsheets/fs220/en/.

[5] South Africa, Department of Health, *Policy Guidelines: Child and Adolescent Mental Health* (2001), p. 4.

mental health and community services); persons with mental health conditions; and persons with psychosocial disabilities, namely, persons who, regardless of self-identification or diagnosis of a mental health condition, face restrictions in the exercise of their rights and barriers to participation on the basis of an actual or perceived impairment. These categorizations may overlap: a user of mental health services may not have a mental health condition and some persons with mental health conditions may face no restrictions or barriers to their full participation in society. The groupings should not determine or undermine the protection of their rights recognized under human rights law, including the rights enshrined in the Convention on the Rights of Persons with Disabilities, the International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights.

III. The right to health framework

6. The right to health is recognized, either explicitly or implicitly, in several human rights instruments, including the International Covenant on Economic, Social and Cultural Rights (art. 12), the Convention on the Rights of the Child (art. 24), the Convention on the Rights of Persons with Disabilities (art. 25) and the Convention on the Elimination of All Forms of Discrimination against Women (arts. 10 (h), 11 (1) (f), 11 (2), 12 and 14 (2) (b)). It is an inclusive right encompassing both timely and appropriate health care and the underlying determinants of health.[6] In the case of mental health, determinants include low socioeconomic status, violence and abuse, adverse childhood experiences, early childhood development and whether there are supportive and tolerant relationships in the family, the workplace and other settings.

7. The right to health contains freedoms (such as the freedom to control one's health and body and the right to be free from interference, torture and non-consensual medical treatment) and entitlements (such as the right to a health system that provides equality of opportunity for people to enjoy the highest attainable level of health).[7] While, in recognition of resource constraints, the right to health is subject to progressive realization, the freedom element in the right to health is subject to neither progressive realization nor resource availability.[8]

8. States parties to the International Covenant on Economic, Social and Cultural Rights have a core obligation to fulfil the minimum essential levels of each right. The core obligations applicable to the right to health include ensuring the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups; ensuring access to adequate food and nutrition; ensuring access to basic shelter, housing and sanitation; providing access to essential drugs; ensuring an equitable distribution of all health facilities, goods and services; and adopting and implementing a national public health strategy and plan of action which address the health concerns of the whole population.[9] Among the obligations of comparable import are the obligations to ensure child health care, to provide education and access to health information and to provide appropriate training for health personnel, including education on health and human rights.[10] These core obligations apply as much to mental health as to physical health.

---

[6] See Committee on Economic, Social and Cultural Rights, general comment No. 14, paras. 4 and 11.

[7] Ibid., para. 8.

[8] See E/CN.4/2005/51, para. 41.

[9] See Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 43.

[10] Ibid., para. 44.

9. The human rights-based approach derived from these norms calls for States to ensure that health facilities, goods and services for mental health are available in sufficient quantity and are accessible and affordable on the basis of non-discrimination. They are also required, among other things, to be gender-sensitive, scientifically and medically appropriate, of good quality and respectful of medical ethics, such as respect for autonomy and agency without discrimination. An integral feature of the right to health, the meaningful participation of all stakeholders in decisions and policies on health, particularly those affected, should be ensured for persons with mental health conditions and others using mental health services through transparent processes.[11] This involves effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health,[12] including mental health. Health authorities and other duty bearers should be accountable for meeting human rights obligations in public health, including through the possibility of seeking effective remedies via complaints mechanisms or other avenues for redress.

10. The formal legal framework has been complemented by the political commitments made in the 2030 Agenda for Sustainable Development, especially Goal 3, which aims to ensure healthy lives and promote well-being for all at all ages. Target 3.4 addresses the reduction of premature mortality from non-communicable diseases and the promotion of mental health and well-being. The prevention and treatment of substance abuse, including narcotic drug abuse and the harmful use of alcohol, fall under target 3.5, while other targets, such as those relating to universal health coverage and tobacco control, focus on areas of clear relevance, even where mental health is not specifically referenced.

IV. Challenges with implications for human rights in mental health

11. The current estimates are that mental health conditions will affect one in four people throughout their lifetime.[13] However, nearly two thirds of persons with mental health conditions will not seek treatment for their condition.[14] Persons with mental conditions also experience disproportionately higher rates of poor physical health for a variety of reasons.[15] One important reason is that poor mental health is a predisposing factor for physical health problems. Another is "diagnostic overshadowing", where symptoms of physical ill-health are erroneously attributed to mental health conditions and, consequently, either not adequately treated or ignored altogether.[16] Stigma is also a significant determinant of quality of care and access to the full range of services required by persons with mental health conditions who also have physical complaints.[17] Research shows that persons with mental health conditions have a much reduced life expectancy compared with the general population, with an estimated drop in life expectancy of 20 years for men and 15 years for

[11] See A/60/348, para. 57.

[12] See Committee on Economic, Social and Cultural Rights, para. 54.

[13] Jessica Mackenzie and Christie Kesner, "Mental health funding and the SDGs. What now and who pays?", Overseas Development Institute (2016), p. 9, and WHO mental health fact sheet (April 2016) available from www.who.int/mediacentre/factsheets/fs396/en/.

[14] WHO, Mental disorders affect one in four people www.who.int/whr/2001/media_centre/press_release/en/.

[15] WHO, "Mental health action plan 2013-2020", para. 11.

[16] Royal College of Psychiatrists, "Whole-person care: from rhetoric to reality. Achieving parity between mental and physical health", occasional paper OP88, (2013), p. 28.

[17] See David Lawrence and Rebecca Coghlan, "Health inequalities and the health needs of people with mental illness", *New South Wales Public Health Bulletin*, vol. 13, No. 7 (July 2002).

women.[18] In some countries, the absence of community-based mental health care means the only care available is in psychiatric institutions, which are associated with gross human rights violations, including inhuman and degrading treatment and living conditions.[19]

A. The experience of living with mental health conditions

1. Barriers to the enjoyment of economic and social rights and the underlying determinants of mental health

12. While statistics are important to understanding the breadth of the challenges presented by mental health conditions, it is the individual who should remain the central figure in the discourse around these questions. The experience of living with mental health conditions is shaped, to a great extent, by the historical and continuing marginalization of mental health in public policy. This manifests itself in, among other areas, social life, inequality of access to opportunities and the overrepresentation of persons with mental health conditions in populations living in poverty.[20] Indeed, today, one of the most important health and human rights challenges is to enhance enjoyment of the right to health for those living in poverty.[21]

13. Mental health is not merely a health issue. There is a strong link between mental health and poverty, as well as between mental health conditions and the economic hardship resulting from the inadequate realization of economic, social and cultural rights, such as the rights to education, work, housing, food and water.[22] These and other rights are also underlying determinants of mental health and, consequently, the extent to which they are realized affects the enjoyment of the right to mental health. The failure to adopt policy approaches which take account of these and other determinants of mental health is, similarly, a major barrier to the realization of the right to mental health.

14. According to the Special Rapporteur on the right to health, the "tendency to undermine the importance of economic, social and cultural rights has led, and continues to lead, to a detrimental combination of poverty, inequalities and disempowerment of large groups of population, who will consequently suffer from poor health status and barriers to accessing health-care services.[23] The interruption of and restricted access to education experienced by many persons with mental health conditions, for instance, limits the opportunities available for obtaining qualifications which would facilitate gainful employment. Difficulty in securing employment and remaining in work or otherwise generating income has negative consequences for the ability to access and retain adequate housing. Taken together, these challenges perpetuate social inequality and have a ruinous and enduring impact on the enjoyment of the right to an adequate standard of living and, consequently, on mental health and access to health services.

---

[18] Kristian Wahlbeck and others, "Outcomes of Nordic mental health systems: life expectancy of patients with mental disorders", *British Journal of Psychiatry*, vol. 199, No. 6 (December 2011). See also Stephen C. Newman and Roger C. Bland, "Mortality in a cohort of patients with schizophrenia: a record linkage study", *Canadian Journal of Psychiatry*, vol. 36, No. 4 (June 1991).

[19] See A/HRC/22/53, paras. 59, 63-70.

[20] See Florida Council for Community Mental Health, "Mental illness and poverty: a fact sheet" (January 2007), available from www.fccmh.org/resources/docs/MentalIllnessandPovery.pdf. See also Sally McManus and others "Adult psychiatric morbidity in England, 2007. Results of a household survey", NHS Information Centre for Health and Social Care (2009).

[21] See A/HRC/4/28, para. 20.

[22] A/HRC/29/33 para. 28.

[23] Ibid., para. 53.

2. Stigma and discrimination

15. There are many negative beliefs around mental health conditions, such as that they are evidence of personal weakness or that they have their origins in witchcraft or spiritual or supernatural phenomena.[24] Together with deeply engrained, adverse stereotypes around persons living with or perceived as having mental health conditions, including the belief that they are incapable of exercising agency over decisions that affect them or of contributing positively to society, these misconceptions have been largely responsible for creating and perpetuating stigma and discrimination.

16. This stereotyping, prejudice and stigmatization is present in every sphere of life, including social, educational, work and health-care settings, and profoundly affects the regard in which the individual is held, as well as their own self-esteem. The lack of systematic training and awareness-raising for mental health personnel on human rights as they apply to mental health allows stigma to continue in health settings, which compromises care. In relation to access to health care, medical insurance schemes often incorporate terms that indirectly discriminate against persons with mental health conditions. Pre-existing conditions or assessments, for instance, may disqualify them from obtaining full health coverage, based on a diagnosis of a mental health condition.

3. Lack of free and informed consent

17. As noted by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, informed consent is not mere acceptance of a medical intervention, but a voluntary and sufficiently informed decision, protecting the right of the patient to be involved in medical decision-making and assigning associated duties and obligations to health-care providers.[25] In order for consent to be valid, it should be given voluntarily and on the basis of complete information on the nature, consequences, benefits and risks of the treatment, on any harm associated with it and on the availability of alternatives.[26] Involuntary treatment refers to the administration of medical or therapeutic procedures without the consent of the individual. Treatment administered, for example, on the basis of misrepresentation would constitute involuntary treatment, as would treatment given under threat, without full information or on dubious medical grounds.[27] Guaranteeing informed consent is a fundamental feature of respecting an individual's autonomy, self-determination and human dignity.[28]

B. Systemic challenges applicable to mental health

18. The right to health entitles rights holders to a health system that supports the attainment of the highest level of health. The concerns identified below have particular relevance in the context of this standard and for the availability, acceptability, accessibility and quality of mental health services.

---

[24] WHO and World Organization of Family Doctors, *Integrating Mental Health into Primary Care: a Global Perspective*, p. 168.

[25] See A/64/272, para. 9.

[26] Ibid., para. 15.

[27] European Agency for Fundamental Rights, "Involuntary placement and involuntary treatment of persons with mental health problems" (2012), pp. 44-47.

[28] See A/64/272, para. 18.

1. Maximum available resources

19. Despite the impact of mental health conditions on individuals, families and communities, there is insufficient investment of both financial and human resources in the area of mental health. Global annual spending on mental health is less than $2 per person and less than $0.25 per person in low-income countries.[29] This affects the provision of services, as inadequate numbers of staff, often with insufficient training, especially in the area of human rights, are required to deliver services which are in accordance with human rights standards. In addition, the largest proportion of most mental health budgets is typically allocated to psychiatric hospitals.[30] This continued investment by Governments in institutional settings, such as psychiatric hospitals, is often accompanied by a corresponding failure to invest in community-based mental health services and supports, which have been widely established as good practices, as more fully explained below. The inadequate allocation of resources and poor decisions taken as to their use, undermine the availability, acceptability, accessibility and quality of mental health services. They also fall foul of article 2 (1) of the International Covenant on Economic, Social and Cultural Rights, which requires States parties to employ their maximum available resources for the progressive realization of the rights recognized in the Covenant, including the right to health.

2. Provision of services in a segregated manner

20. Although there has been progress over the last few decades, the segregation and centralization of mental health services around psychiatric hospitals and institutions continues to pose a challenge in certain important respects. The failure to integrate interdisciplinary mental health services into primary care renders a "whole person" approach extremely difficult. In many countries, there are no mental health services available in local health clinics and general hospitals, forcing people in remote areas to travel long distances, often at high cost. Where mental health care and support services are provided in segregated systems and social care institutions, there is a higher risk of human rights violations.[31]

3. Valuing mental health

21. In the context of health, the concept of parity of esteem refers to valuing mental health equally with physical health.[32] From a normative standpoint, the framework which establishes the right to health does not create a hierarchy where mental health is ranked lower than physical health. The strong relationship between physical and mental health calls for an approach which accords equal value to both and yet a lack of parity of esteem, where preferential consideration is given to physical health, remains the dominant perspective. Consequently, among other discrepancies, fewer financial and human resources are allocated for mental health and many mental health facilities tend to be dilapidated, with lower hygiene standards and fewer amenities. There are also significant data and research gaps in mental health, particularly in relation to the identification of the human rights situation of persons with mental health conditions and users of mental health services, and the impact of policy measures.

---

[29] See WHO, "Mental health action plan 2013-2020", para. 14.

[30] WHO, Mental Health Atlas 2014, p. 9.

[31] See E/CN.4/2005/51, para. 8.

[32] Royal College of Psychiatrists, "Whole-person care: from rhetoric to reality", p. 20.

V. The human rights-based approach to disability in the context of mental health

22. The Convention on the Rights of Persons with Disabilities adopts a human rights-based approach to disability and supersedes previous international "soft law" developments, including the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care. It reflects the most advanced international human rights standards on the rights of persons with psychosocial disabilities.

23. The human rights-based approach to disability, in addition to other principles, requires the unconditional application of the principle of non-discrimination with regard to persons with disabilities. No additional qualifiers associated with an impairment may justify the restriction of human rights. For example, persons with psychosocial disabilities should not be arbitrarily deprived of their liberty on the basis of their impairment including in conjunction with an alleged danger to themselves or to others.[33] Mental health policy should adopt and integrate this approach and guard against lowering standards.

24. Widespread practices circumvent the substantive equality approach for persons with psychosocial disabilities in public and private settings, including through the failure to provide reasonable accommodation, that is, the necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.[34] Disability determination or certification schemes, where they exist, may not recognize them as persons with disabilities, which can lead to their exclusion from disability-specific social protection schemes.

A. Equal recognition before the law

25. Article 12 of the Convention on the Rights of Persons with Disabilities affirms the right of persons with psychosocial disabilities to equal recognition before the law, upholding their right to exercise legal capacity on an equal basis with others. In the area of mental health, legal capacity has an important application in the exercise of free and informed consent. Many national laws continue to allow for the denial of legal capacity of persons with psychosocial disabilities, precluding them from making their own decisions. These substituted decision-making regimes commonly permit third parties to provide consent for treatment or admission for treatment on behalf of the person concerned.

26. States should repeal legal frameworks allowing substitute decision makers to provide consent on behalf of persons with disabilities and introduce supported decision-making, ensuring its availability for those who request it. Health service providers should seek the free and informed consent of the person concerned by all possible means.[35]

27. Compliance with the standards on accessibility of information and communications in the Convention on the Rights of Persons with Disabilities is a key precondition for the exercise of legal capacity and free and informed consent. For example, information on treatments and side-effects is often not available in Braille, sign language, or other alternative modes of communication. While health services may progressively advance in

[33] See CRPD/C/DNK/CO/1, para. 36 and CRPD/C/SWE/CO/1, para. 35.

[34] Convention on the Rights of Persons with Disabilities, art. 2.

[35] See Committee on the Rights of Persons with Disabilities, general comment No. 1 (2014) on equal recognition before the law, para. 41.

complying with accessibility requirements, they do have an immediate obligation to provide reasonable accommodation.[36]

28. In certain situations, the will of the person concerned might be difficult to determine. Instruments such as advance directives or powers of attorney should be promoted and clearly formulated to prevent misunderstanding or arbitrariness by those executing them. Even when such instruments are in force, persons with psychosocial disabilities must always retain their right to modify their will and service providers should continue to seek their informed consent. The Committee on the Rights of Persons with Disabilities has held that, in all cases, it should be understood that article 12 of the Convention on the Rights of Persons with Disabilities prohibits resorting to the principle of the "best interests" of the individual in relation to adults with disabilities.[37] Significant efforts must be made to determine the individual's will and preferences, ensuring that all possible accommodations, supports and diverse methods of communication are made available and accessible. Where all means have been exhausted and the individual's will remains undetermined, the principle of "the best interpretation of will and preferences of the individual" must be upheld and carried out in good faith.[38]

B. The absolute ban on deprivation of liberty on the basis of impairments

29. Article 14 of the Convention on the Rights of Persons with Disabilities establishes an absolute ban on deprivation of liberty on the basis of impairments, which precludes non-consensual commitment and treatment.[39] This provision reflects the non-discriminatory approach guaranteed by the Convention in connection with the right to liberty and security of person. The Committee on the Rights of Persons with Disabilities has clearly and consistently confirmed the non-discriminatory approach to the right to liberty, which establishes the unambiguous prohibition on deprivation of liberty on the basis of impairments, whether or not it is connected with other factors.

30. Persons with psychosocial disabilities continue to be subjected to forced institutionalization, as allowed by civil codes and mental health laws in many countries. Deprived of their liberty, they are commonly subjected to forced treatment, and living conditions and arrangements may also put their physical and mental integrity at risk. Children or adults detained in institutions are at increased risk of violence and abuse, including sexual exploitation and trafficking.[40] The Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment has found that children in residential or institutional care are at greater risk of mental health trauma, violence and abuse, and that the severe emotional pain and suffering caused by segregation may rise to the level of ill-treatment or torture.[41] Outside of institutions, the use of community treatment orders or mandatory outpatient treatment, even if enforced in the community, violates the right to

[36] See A/HRC/34/26, para. 33.

[37] See Committee on the Rights of Persons with Disabilities, general comment No. 1, para. 21.

[38] Ibid., para. 21.

[39] See Committee on the Rights of Persons with Disabilities, guidelines on article 14 of the Convention, paras. 6 and 10.

[40] See, for example, Disability Rights International and the Comisión Mexicana de Defensa y Promoción de los Derechos Humanos, "Abandoned and disappeared: Mexico's segregation and abuse of children and adults with disabilities" (2010). See also Disability Rights International, "No justice: torture, trafficking and segregation in Mexico" (2015); "Left behind: the exclusion of children and adults with disabilities from reform and rights protection in the Republic of Georgia" (2013); and "International collaboration for inclusion: a study funded by the United States Department of State" (2014). Available at www.driadvocacy.org.

[41] A/HRC/28/68.

liberty and security of the person as such measures impose treatment and the threat of detention if refused.

31. Forced institutionalization violates the right to personal liberty and security, understood as freedom from confinement of the body and freedom from injury to one's bodily or mental integrity, respectively. [42] It amounts to a violation of the right to live free from torture and ill-treatment,[43] and from exploitation, violence and abuse, and of the right to personal integrity. States parties should repeal legislation and policies that allow or perpetuate involuntary commitment, including its imposition as a threat, and should provide effective remedies and redress for victims.[44]

32. Criminal law and procedures commonly deny due process of law to persons with disabilities considered unfit to stand trial and/or incapable of criminal responsibility, leading to deprivation of liberty on the basis of impairment, including through the diversion of persons with psychosocial disabilities into the custody of forensic institutions. The Committee on the Rights of Persons with Disabilities has consistently considered that this denies fair trial rights, amounts to arbitrary detention and often leads to harsher consequences than criminal sanctions, such as indefinite detention in mental health facilities.

C. Forced treatment: forced medication, overmedication and harmful practices during deprivation of liberty

33. Many practices within mental health institutions also contravene articles 15, 16 and 17 of the Convention on the Rights of Persons with Disabilities. Forced treatment and other harmful practices, such as solitary confinement, forced sterilization, the use of restraints, forced medication and overmedication (including medication administered under false pretences and without disclosure of risks) not only violate the right to free and informed consent, but constitute ill-treatment and may amount to torture. [45] Accordingly, the Committee on the Rights of Persons with Disabilities has called for the abolition of all involuntary treatment and the adoption of measures to ensure that health services, including all mental health services, are based on the free and informed consent of the person concerned.[46] The Committee has also urged the elimination of the use of seclusion and restraints, both physical and pharmacological.[47]

VI. Charting the way forward

34. Mental health is not merely a health or medical concern, it is very much a matter of human rights, dignity and social justice. The overview of the challenges facing persons with mental health conditions and those with psychosocial disabilities indicates that fundamental

---

[42] See Human Rights Committee, general comment No. 35 (2014) on liberty and security of person, para. 3.

[43] See A/63/175, paras. 47 and 65.

[44] See, for example, CRPD/C/CZE/CO/1, para. 33; CRPD/C/DEU/CO/1, para. 34 (c); CRPD/C/KOR/CO/1, para. 32 and A/HRC/30/37, para. 107 (f).

[45] See Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 50, Committee on the Rights of Persons with Disabilities, general comment No. 1, paras. 37 and 41 and A/HRC/22/53, para. 63.

[46] See, for example, CRPD/C/ESP/CO/1, para. 36; CRPD/C/HUN/CO/1, para. 28 and CRPD/C/AUT/CO/1, para. 31.

[47] See, for example, CRPD/C/AUT/CO/1, para. 33; CRPD/C/MEX/CO/1, para. 32; and CRPD/C/DNK/CO/1, para. 39.

changes are necessary in current approaches to the protection of their rights and how that protection is implemented in policy. Key to this is recognizing that the individuals concerned, including children, have agency, self-determination and rights, which should be protected and respected.

35. The following sections of the report include recommendations for action to implement the changes necessary to address the challenges identified. They are organized, structurally, around the integration of a human rights-based approach, good practices and technical support and capacity-building, although their cross-cutting objective is, ultimately, the protection of the rights of the groups identified in Council resolution 32/18.

A. Human rights-based approach

1. Data collection

36. The collection of comprehensive qualitative and quantitative data is a vital component of a human rights-based approach. In the context of mental health, data collection should focus, inter alia, on resource allocation, disparities in access to health care and support, the identification of the most vulnerable and marginalized, patterns of discrimination, access to employment, housing and education, and the general socioeconomic situation of persons using mental health services. Data should be disaggregated by age, sex, socioeconomic status, disability and other factors, as relevant to the national context, and should be utilized to inform policy formulation and legislation and develop effective responses.

2. Creating an enabling legal and policy environment for the enjoyment of rights

37. Few countries have a legal framework that adequately protects the rights of users of mental health services, persons with mental health conditions or those with psychosocial disabilities. Given the direct impact of laws and policies on the realization of human rights, a legal and policy environment which upholds them is vital and furthermore is mandated by the obligation of States to respect, protect and fulfil rights.

38. A thorough review of laws and policies, with a view to establishing the extent to which persons with mental health conditions, users of mental health services and persons with psychosocial disabilities enjoy their human rights, both within the mental health system and in the broader social context, is an essential first step to ensuring an enabling environment. The policy and law review should be evaluated against the human rights standards outlined in the present report and should specifically integrate a focus on the underlying determinants of mental health. Action mandated by the relevant findings should form part of a national strategy and plan on mental health, the implementation of which is backed by adequate resources.

39. Following this human rights-based assessment, States should update or repeal, as appropriate, all existing laws, including legislation on employment, equality and non-discrimination, social protection, housing and education, to ensure that persons with mental health conditions are not discriminated against and have the same opportunities on an equal basis with others.

40. A human rights-based approach to mental health requires attention to its underlying determinants which, as noted earlier, include violence and abuse, adverse childhood experiences, early childhood development and whether there are supportive and tolerant relationships in the family, the workplace and other settings. Addressing these and other determinants involves coordinated action across the health and other relevant sectors with a view to ensuring policy coherence and the full protection of the rights of persons with mental health conditions, as outlined in the present section.

41. Other interventions include the promulgation of laws and policies to:

(a) Address and eliminate stigma and discrimination;

(b) Protect the principle of free and informed consent for treatment and prohibit involuntary treatment and detention;

(c) Protect individuals from human rights violations in health settings;

(d) Prohibit recourse to all forms of substitute decision-making;

(e) Ensure the availability of and equitable access to services and support for persons with mental health conditions and those with psychosocial disabilities, including those in prisons and other detention facilities;

(f) Ensure expeditious access to justice where human rights violations have occurred.

42. Regarding mental health and disability specifically, mental health laws, where they exist, should avoid the separate regulation of legal capacity, the right to liberty and security, or other aspects of the law which are amenable to being mainstreamed into general legislation. In all cases, laws and regulations should be compliant with articles 5, 12, 13, 14, 15, 16, 17 and 25 of the Convention on the Rights of Persons with Disabilities, among other provisions, and should: (a) prohibit the arbitrary deprivation of liberty on the basis of impairment, irrespective of any purported justification based on the need to provide "care" or on account of "posing a danger to him or herself or to others"; (b) ensure the individual's right to free and informed consent in all cases for all treatment and decisions related to health care, including the availability and accessibility of diverse modes and means of communication, information and support to exercise this right; and (c) in accordance with the standards of the Convention, develop, adopt and integrate into the legal framework the practice of supported decision-making, advance directives and the principle of "the best interpretation of the will and preferences" of the person concerned as a last resort.

3. Participation

43. The full participation of affected communities in the development, implementation and monitoring of policy has a positive impact on health outcomes and on the realization of their human rights. Ensuring their participation supports the development of responses that are relevant to the context and ensures that policies are effective.[48] Participation in law-making and policy design in mental health has typically been directed at health professionals, as a result of which the concerns and views of users, persons with mental health conditions and persons with psychosocial disabilities have not been systematically taken into account and harmful practices have been perpetuated and institutionalized in law and policies.

44. States should, therefore, ensure that users of mental health services, persons with mental health conditions and persons with psychosocial disabilities participate meaningfully during all stages of planning and implementation, as envisaged in article 4 (3) of the Convention on the Rights of Persons with Disabilities and recommended by the Committee on Economic, Social and Cultural Rights in its general comment No. 14 (para. 54). With this objective, States should build the capacity of users, persons with mental health conditions and those with psychosocial disabilities to participate and to claim their rights. An effective strategy will include education and awareness-raising, and ensuring that

[48] See Joint United Nations Programme on HIV/AIDS, "Non-discrimination in HIV responses" (June 2010), paras. 18-22.

transparent and accessible mechanisms for participation are established or strengthened at community, subnational and national levels.[49]

4. Resources

45. As noted above, the current expenditure on mental health falls far short of need and fails to meet the requirement in the International Covenant on Economic, Social and Cultural Rights to use the maximum available resources. In order to address this, priority should be given to the development and adequate resourcing of human rights-based strategies and plans on mental health, informed by the law and policy review recommended above. Resources should, among other things, be directed towards: (a) raising the quality of health care as well as ensuring availability, accessibility and acceptability; (b) improving working conditions for mental health personnel; (c) strengthening health workforce training, including in human rights; (d) ensuring the provision of the full range of support services; (e) achieving equality between mental and physical health services across all domains, including resource allocation, research and data; (f) emergency mental health services; (g) community-based mental health services; (h) mental health promotion;[50] and (i) ensuring access to education, adequate housing, support for securing and retaining employment, and social protection

46. An overarching principle which should inform policy in this area is the duty of States to invest resources in practices that uphold human rights and to adopt "do no harm" evaluation criteria to avoid further human rights violations. Indeed, resource allocation towards existing practices in mental health, which are contrary to international human rights standards, may amplify the impact of harmful practices.

5. Accountability

47. Monitoring, review, remedial measures and corrective action, guided by human rights-based, context-specific indicators, are cornerstones of any accountability framework.[51] Accountability should have as both a goal and a result the empowerment of users, persons with mental health conditions and those with psychosocial disabilities, including through legal and policy measures to ensure their participation in priority-setting and policy formulation, implementation and review, and to ensure access to remedial measures where appropriate.[52]

48. Ensuring access to justice in accordance with article 13 of the Convention on the Rights of Persons with Disabilities is essential to guaranteeing the redress of and reparations for human rights violations, including arbitrary detention on the basis of impairment. Effective remedies, available on an expedited basis, should be in place to challenge the deprivation of liberty and uphold the principle of informed consent to medical treatment. Practices that effectively deny fair trial rights (such as the denial of legal capacity by requiring a guardian to act on a person's behalf), or that may prevent access to legal remedies (such as mandatory legal representation), should be discontinued and prohibited by law.

49. Article 16 of the Convention on the Rights of Persons with Disabilities calls for the establishment of independent monitoring mechanisms for all services and facilities serving

---

[49] Jyoti Sanghera and others, "Human rights in the new Global Strategy", *BMJ* (September 2015).

[50] Mackenzie and Kesner, "Mental health funding and the SDGs", p. 12.

[51] Independent Accountability Panel, "2016: Old challenges, new hopes. Accountability for the Global Strategy for Women's, Children's and Adolescents' Health" (2016), pp. 9-11.

[52] Commission on Information and Accountability for Women's and Children's Health, "Keeping promises, measuring results" (2011), p. 7.

persons with disabilities in order to prevent exploitation, violence and abuse. These mechanisms should include representative organizations of persons with disabilities and civil society, and should be able to access and monitor institutions while States move towards deinstitutionalization. This monitoring role should extend to mental health and community services to ensure that they are conducive to inclusion, participation and the overall enjoyment of rights on equal basis with others. When abuses in institutions are identified, States should, as required by article 16 of the Convention, take appropriate measures to "promote the physical, cognitive, and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse".

50. Other measures to promote accountability include the establishment of transparent, inclusive and participatory processes and mechanisms, with jurisdiction to recommend and enforce remedial action, in both the health and justice systems. Such mechanisms and processes include courts or quasi-judicial and non-judicial bodies, complaints mechanisms within the health system, national human rights institutions and professional standards associations.[53]

B. Good practices

1. Mental health care based on recovery

51. Community-based service delivery for mental health should encompass a recovery-based approach that places the emphasis on supporting individuals with mental health conditions in achieving their own aspirations and goals.[54] A recovery-based approach to mental health is centred on the strengths of the individual and on facilitating access to the supports he or she needs, it integrates an understanding of trauma and involves persons with lived experiences in mental health in the provision of services. This approach requires "listening and responding to individuals' understanding of their condition and what helps them to recover [and] working with people as equal partners in their care".[55]

52. Given the close relationship between mental health conditions and trauma, all mental health services should be "trauma-informed" and designed to avoid re-traumatization, and staff should be trained to recognize and refrain from engaging in practices that might trigger painful memories and re-traumatize persons with trauma histories.[56]

53. Finally, persons with mental health conditions are the foremost experts in their own recovery and in assisting others in their recovery. Peer workers provide each other with support and a sense of belonging, in addition to their expertise, thus reducing unnecessary admissions, and their use is central to mental health care.[57]

2. Community-based services

54. The Committee on Economic, Social and Cultural Rights has recommended that health facilities, goods and services be located within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as persons with

---

[53] Sanghera and others "Human rights in the new Global Strategy".

[54] WHO, "Mental health action plan", para. 50.

[55] Ibid.

[56] United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration, "SAMHSA's concept of trauma and guidance for a trauma-informed approach" (July 2014), p. 10.

[57] See WHO, "Mental health action plan", para. 50.

disabilities.[58] Evidence shows that the provision of interdisciplinary and demedicalized services in the community enables users to remain connected with their families, to maintain employment and generally to remain close to the support networks which facilitate early treatment and recovery. Mental health services, particularly in more developed countries and, increasingly, in developing countries, are usually provided within specialized systems centred around psychiatric hospitals, in which many practices contradictory to the standards in the Convention on the Rights of Persons with Disabilities continue to take place. In order to guarantee the right to access to services for persons with mental health conditions and psychosocial disabilities, States should ensure the availability of recovery-based treatment in the community and in the primary care system.

3. Deinstitutionalization

55. The implementation of article 19 of the Convention on the Rights of Persons with Disabilities on the right to live independently and to be included in the community is essential for persons with psychosocial disabilities. The recovery approach is consistent with the purpose of supporting the person in all aspects of their life, personal development, exercise of autonomy and participation and inclusion in the community.

56. Ensuring that persons with disabilities choose where and with whom they live and upholding autonomy fosters inclusion in the community. Institutionalization and institutionalized living arrangements, whether in large facilities or smaller group homes, amount to segregation and are inconsistent with inclusion in the community. The Committee on the Rights of Persons with Disabilities has repeatedly expressed concern about the institutionalization of persons with disabilities and the lack of support services in the community, and has recommended implementing support services and effective deinstitutionalization strategies in consultation with organizations of persons with disabilities.[59]

57. Effective deinstitutionalization requires an understanding that the right to community living is more than just access to a physical placement in the community.[60] Social support for persons with psychosocial disabilities must be made available at the same time, including supported and assisted housing, health care, crisis response systems, income support, support for social networks and access to education and work.[61] Social networks, peer support, circles of support and local community support are valuable, in particular to address situations of crisis and emergency; they must be acknowledged and their development supported.

4. Children

58. At least 8 million children live in institutions.[62] The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has reported that institutional care in early childhood has such harmful effects that it should be considered a form of violence against young children.[63] In accordance with international human rights and good practice norms, States should (a) end the institutionalization of all children, with and without disabilities; (b) place a moratorium on

[58] See general comment No. 14, para. 12 (b).
[59] See, for example, CRPD/C/ESP/CO/1, paras. 35-36; CRPD/C/CHN/CO/1, para. 26; CRPD/C/ARG/CO/1, para. 24.
[60] Ibid.
[61] WHO and World Bank, *World Report on Disability* (2011), p. 148.
[62] See A/61/299, para. 55.
[63] See A/70/213, para. 73.

new admissions of children with disabilities into institutions;[64] (c) protect the right of children with disabilities to live in the community and the right of all children to grow up in a family;[65] (d) seek alternative family placement rather than any form of residential care for children who must be removed from their own family; [66] (e) as provided for under article 23 (5) of the Convention on the Rights of Persons with Disabilities, provide alternative care "within the wider family, and failing that, within the community in a family setting",[67] where the immediate family is unable to care for the child; and (f) ensure that deinstitutionalization in the case of children is focused on reintegrating them into a family rather than into a smaller institution.

5. Adequate standard of living

59. Housing and social protection policies, as envisaged in articles 19 and 28 of the Convention on the Rights of Persons with Disabilities, are essential for ensuring an adequate standard of living for persons with psychosocial disabilities. Assistance for housing and family and for the elimination of poverty, malnutrition and social exclusion has an overall positive impact on the physical and mental health of persons with psychosocial disabilities. In tandem with such measures, States should promote the inclusion of persons with psychosocial disabilities in the open labour market so that they are assured of an income. States should also raise awareness and provide technical guidance and support on how to provide reasonable accommodation for persons with psychosocial disabilities in the workplace.

C. Technical support and capacity-building

60. Articles 2.1 of the International Covenant on Economic, Social and Cultural Rights and 32 of the Convention on the Rights of Persons with Disabilities provide the main normative bases for technical support and capacity-building in the area of mental health. Under the Covenant, States have a duty to take steps through international assistance and cooperation, especially economic and technical cooperation, towards the progressive realization of the right to health. As noted by the Committee on Economic, Social and Cultural Rights, there is a particular obligation for States in a position to assist to provide this assistance to other countries.

61. With respect to persons with psychosocial disabilities, the following measures and activities are critical for strengthening technical assistance and capacity-building at the national level. They require the active engagement, participation, involvement and inputs of people with lived experience of psychosocial disabilities, and their representative organizations:

(a) Technical support to countries to develop and implement policies, plans, laws and services that promote and protect the rights of persons with psychosocial disabilities in line with international human rights standards including the Convention on the Rights of Persons with Disabilities;

---

[64] United Nations Children's Fund, *The State of the World's Children*, p. 80.

[65] See, for example, CRPD/C/GTM/CO/1 and CRPD/C/CZE/CO/1.

[66] Eric Rosenthal, "A mandate to end placement of children in institutions and orphanages: the duty of governments and donors to prevent segregation and torture (2017). Available from https://www.law.georgetown.edu/academics/centers-institutes/human-rights-institute/our-work/research/upload/Perspectives-on-Human-Rights-Rosenthal.pdf.

[67] Ibid.

(b) Capacity-building among mental health practitioners, persons with psychosocial disabilities, families, carers and other supporters, civil society, lawyers, judges, police, social workers and others in order to promote a human rights, legal capacity and recovery-based approach in the area of mental health in line with the Convention on the Rights of Persons with Disabilities and other international human rights standards;

(c) Comprehensive technical guidance for countries which identifies, describes and evaluates existing and emerging community-based services and support that are responsive to the needs of persons with psychosocial disabilities and are in line with the Convention on the Rights of Persons with Disabilities;

(d) Support for the creation and strengthening of organizations led by persons with psychosocial disabilities and the facilitation of dialogue with Governments in order to facilitate their inclusion and participation in policymaking processes;

(e) Addressing the perpetuation of segregation, which may take the form of funding new institutions or refurbishing existing facilities, through the termination of resource allocations to these areas. Funding should be used to help families avoid placement of children in institutions and to create community-based support systems for persons with psychosocial disabilities.

VII. Conclusions

62. **Users of mental health services, persons with mental health conditions and persons with psychosocial disabilities are positioned at the confluence of many vulnerabilities, particularly those arising from poverty, stigma, discrimination, social isolation and segregation. A comprehensive approach to addressing their human rights situation requires the protection of autonomy, agency and dignity as well as the other human rights guaranteed by, inter alia, the Convention on the Rights of Persons with Disabilities and the International Covenant on Economic, Social and Cultural Rights. It also requires policy shifts that recognize exclusion and marginalization as the causes and consequences of poor mental health and take seriously the commitment in the 2030 Agenda for Sustainable Development to leave no one behind and reach first those who are furthest behind. Consequently, in meeting their obligation to achieve the full realization of the rights of persons with mental health conditions, users of mental health services and persons with psychosocial disabilities, States should align the policy and legal framework with human rights norms, develop and implement rights-based strategies and plans, and share technical expertise and other resources, such as good practice norms.**